Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
PRESBYTERIAN HOSPITAL OF DALLAS
P.O. BOX 203500
AUSTIN, TX 78720-3500

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-08-5366-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
01

MFDR Date Received
APRIL 18, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated March 10, 2008: "It has come to our attention that his bill has been audited incorrectly. This bill qualifies as a **STOP LOSS** bill per rule 134.401. If audited charges exceed $40,000.00 carrier should reimburse 75% of total charges (**134.401 C (6)).** Per **Stop Loss rule, method is to be used in place of and not in addition to the per diem/Fair and Reasonable** or any other method of audit. In addition, the **only items allowable** by DWC for the carrier to deduct are patient convenience items and non-compensable are treatment. "

Amount in Dispute: $108,724.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated May 7, 2008: "We based our payments on the Texas Fee Guidelines and the Texas Department of Insurance/Division of Workers' Compensation Commission's Acts and Rules … The provider was required to obtain pre-authorization for additional days a required by TWCC rule §413.014 and §408.0042 as amended in 2005. The provider was originally sought pre-authorization and was approved for a 3 day inpatient stay; however, the provider did not seek additional authorization as required for the additional 4 days."

Response Submitted by: Liberty Mutual

Respondent's Supplemental Position Summary Dated November 22, 2001: " Liberty Mutual believes that Presbyterian Hospital of Dallas has been appropriately reimbursed for services rendered to [Injured Worker] for the 4/19/2007 through 4/24/2007 dates of service."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 19, 2007 through April 26,2007	Inpatient Hospital Services	$108,724.11	$2,766.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 33 *Texas Register* 428, effective January 17, 2008, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 42 Z710 – The charge for this procedure exceeds the fee schedule allowance
- 24 P303 - This service was reviewed in accordance with your contract
- 62 X170 – Pre-authorization was required, but not requested for this service per TWCC Rule 134.600

Issues

1. Is denial code 24 P303 supported?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The insurance carrier reduced or denied disputed services with reason code 24 P303 – "This service was reviewed in accordance with your contract." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $179.386.81. The division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "It has come to our attention that his bill has been audited incorrectly. This bill qualifies as a **STOP LOSS** bill per rule 134.401. If audited charges exceed $40,000.00 carrier should reimburse 75% of total charges (134.401 C (6)). Per **Stop Loss rule, method is to be used in place of and not in addition to the per diem/Fair and Reasonable** or any other method of audit. In addition, the **only items allowable** by DWC for the carrier to deduct are patient convenience items and non-compensable are treatment." In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

4. In regards to whether the services were unusually costly, the requestor presupposes that because the bill exceeds $40,000, the stop loss method of payment should apply. The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - The length of stay was five days; however, documentation supports that the Carrier pre-authorized a length of stay of three days in accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is $3,354.00 for the three authorized days.
   - 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $3,975.00 for revenue code 390 – Blood/Stor-Proc, and $1,580.25 for revenue code 391 – Blood/Admin. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 390 and 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
   - The division notes that 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that the following items were billed under revenue code 0274 and 0278 and are therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Charge Code	Itemized	Cost Invoice	UNITS /	Total Cost	Cost + 10%

	Statement Description	Description	Cost Per Unit		
6008462	Floseal Hemos	Floseal Hemostatic Matrix	2 billed, invoice documents 1 at $900.00 ea	$900.00	$990.00
6020637	Graft Bone In	Graft Bone Infuse lg	1 at $5,100.00 ea	$5,100.00	$5,610.00
6022517	Cage Staple	Staple, 20 MM	1 at $1,245.00 ea	$1,245.00	$1,369.50
6022784	Graft Matric	No Invoice	$0.00	$0.00	$0.00
6024201	Rod Prebent	MMSI Rod Prebent, 5.5 x 35MM	1 at $450.00 ea	$450.00	$495.00
6024555	Cage Staple	No Invoice	$0.00	$0.00	$0.00
6025424	Rod prebent	MMSI Rod Prebent, 5.5 x 40MM	1 at $450.00 ea	$450.00	$495.00
6026317	Bone Granules	Granules Conduit TCP15CC	1 at $790.00 ea	$790.00	$869.00
6028349	Cage Cougar	Cougar Implant Sm 14MM 5Deg	1 at $5,780.00 ea	$5,780.00	$6,358.00
6060122	Screw polyaxi	SI polyaxl Screw 6 x 45MM	4 at $1,555.00 ea	$6,220.00	$6,842.00
6060124	Screw Set Exp	Singer – Inner Setscrew	4 at $275.00 ea	$1,100.00	$1,210.00
5000361	Brace Orthosi	Rigid LSO Brace	1 at $900.00 ea	$900.00	$990.00
			TOTAL ALLOWABLE	$25,228.50	

The division concludes that the total allowable for this admission is $3,354.00 + 25,228.50. The respondent issued payment in the amount of $25,816.00. Based upon the documentation submitted, additional reimbursement in the amount of $2,766.50 is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement..

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $2,766.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/24/12
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.